

UNITED STATES DISTRICT COURT
DISTRICT OF OREGON
PORTLAND DIVISION

RICHARD L. CORESON,)
)
Plaintiff,) No. 03:13-cv-01979-HU
)
vs.)
)
CAROLYN W. COLVIN,) **FINDINGS & RECOMMENDATIONS**
Commissioner of Social Security,)
)
Defendant.)

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HUBEL, United States Magistrate Judge:

The plaintiff Richard L. Coreson seeks judicial review, pursuant to 42 U.S.C. § 405(g), of the Commissioner's final decision denying his application for Disability Insurance ("DI") benefits under Title II of the Social Security Act, 42 U.S.C. § 1381 *et seq.* Coreson argues the Administrative Law Judge ("ALJ") erred in rejecting the opinion of Coreson's treating physician, failing to give legally sufficient reasons for rejecting portions of Coreson's testimony, and rejecting lay witness testimony without offering reasons "germane" to the witness. See Dkt. ##12 & 18.

I. PROCEDURAL BACKGROUND

Coreson protectively filed his application for DI benefits on September 29, 2010, claiming disability since November 17, 1998, when he was 50 years old. (A.R. 11¹; 141-42) Coreson claims he is disabled due to a combination of conditions including HIV, bronchitis, rheumatoid arthritis, PSVT (paroxysmal supraventricular tachycardia²), mitral valve prolapse³, and high cholesterol. (See

¹The administrative record ("A.R.") was filed electronically using the court's CM/ECF system. Dkt. #8 and attachments. Pages of the A.R. contain at least three separate page numbers: two located at the top of the page, consisting of the CM/ECF number (e.g., Dkt. #8-3, Page 12 of 57) and a Page ID#; and a page number located near the upper right of the page, representing the numbering inserted by the Agency. Some pages also contain a page number inserted by the office supplying the records. Citations herein to "A.R." refer to the agency numbering near the lower right corner of each page.

²"Paroxysmal supraventricular tachycardia (PSVT) is episodes of rapid heart rate that start in a part of the heart above the ventricles." Symptoms of the condition "most often start and stop suddenly. They can last for a few minutes or several hours." Symptoms may include anxiety, chest tightness, palpitations, rapid

(continued...)

1 A.R. 155) He claims he has been unable to work since 1998, because
 2 his symptoms and medications cause severe fatigue, and pain and
 3 swelling in his hands and knees, resulting in extreme limitations
 4 in his physical functional abilities. (A.R. 166-67)

5 Coreson's application was denied initially and on recon-
 6 sideration. (A.R. 77-80; 86-88) Coreson requested a hearing, and
 7 a hearing was held on August 7, 2012, before an ALJ. Coreson was
 8 represented by an attorney at the hearing. Witnesses at the hear-
 9 ing included Coreson, his daughter Latricia Payer, a vocational
 10 expert ("VE"), and a medical expert. (A.R. 23-56) On September 6,
 11 2012, the ALJ issued his decision, denying Coreson's application
 12 for benefits. (A.R. 11-19) Coreson appealed the ALJ's decision,
 13 and on September 24, 2013, the Appeals Council denied his request
 14 for review (A.R. 1-5), making the ALJ's decision the final decision
 15 of the Commissioner. See 20 C.F.R. §§ 404.981, 416.1481. Coreson
 16 filed a timely Complaint in this court seeking judicial review of
 17 the Commissioner's final decision denying his application for DI
 18 benefits. Dkt. #1. The matter is fully briefed, and the under-
 19 signed submits the following findings and recommended disposition
 20 of the case pursuant to 28 U.S.C. § 636(b)(1)(B).

21
 22 ²(...continued)
 23 pulse, shortness of breath, and sometimes dizziness and fainting.
 24 <http://www.nlm.nih.gov/medlineplus/ency/article/000183.htm> (visited
 10/23/2014).

25 ³Mitral valve prolapse (MVP) occurs when one of [the] heart's
 26 valves is "floppy," and fails to close tightly. "Most of the time,
 27 MVP doesn't cause any problems. Rarely, blood can leak the wrong
 28 way through the floppy valve." When that occurs, symptoms may
 include palpitations; shortness of breath; coughing; fatigue;
 dizziness; anxiety; migraine headaches; and chest discomfort.
<http://www.nlm.nih.gov/medlineplus/mitralvalveprolapse.html>
 (visited 10/23/2014).

3 - FINDINGS & RECOMMENDATIONS

1 Preliminarily, the court notes Coreson previously filed an
2 application for benefits in approximately 2000, which resulted in
3 a hearing, and a denial by an ALJ dated March 31, 2004. (See A.R.
4 28-29) Because Coreson's date last insured was December 31, 2004
5 (see A.R. 26-27), the prior denial would still leave a period for
6 consideration prior to his date last insured. (See A.R. 29)
7 However, the ALJ in the present case noted the file from the prior
8 application for benefits likely had been destroyed, or at least it
9 could not be located. The ALJ therefore indicated he would "go
10 ahead and consider the evidence for the entire period alleged,
11 rather than just considering the evidence for that particular
12 limited period." (*Id.*) In other words, in the present case, the
13 ALJ considered "the period from the alleged onset date, which is
14 November 17th of 1998, through the date last insured, December 31,
15 2004." (*Id.*)

16 17 **II. FACTUAL BACKGROUND**

18 **A. Summary of the Medical Evidence**

19 Coreson first applied for private disability benefits "when he
20 became unable to work in 1998." (A.R. 126) At that time, Coreson
21 was working as "a managerial employee at the Oregon Department of
22 Fish and Wildlife[.]" (*Id.*) Ensuing litigation regarding coverage
23 ultimately was "resolved in favor of Mr. Coreson." (A.R. 126) As
24 part of that litigation, on January 6, 2000, Coreson's treating
25 physician Douglas Beers, M.D. gave a deposition in which he testi-
26 fied extensively regarding Coreson's condition from about 1992
27 forward. (See A.R. 209-49) In the present case, Coreson relies
28 heavily on Dr. Beers's testimony.

1 Dr. Beers testified that he is board-certified in Internal
2 Medicine. He described himself as "an HIV specialist," and he is
3 extensively involved in clinical research and education regarding
4 HIV. (A.R. 201-02) He sees patients for a variety of medical
5 problems, including about 250 HIV patients (amounting to about 20%
6 of his practice). (A.R. 203-04) According to the doctor, he has
7 "the largest HIV practice in the state," and he considers himself
8 to be an expert in the treatment of HIV. (A.R. 204-05)

9 Dr. Beers did not recall when he first began seeing Coreson,
10 noting his earliest records were unavailable. However, he believed
11 an attending physician's statement was correct in stating he had
12 been seeing Coreson since 1990. (A.R. 205-06)

13 Dr. Beers's records from November 1998, indicated at that time
14 Coreson "was really suffering from profound fatigue, generalized
15 achiness, and depression . . . [a]ll of which are characteris-
16 tically very interrelated." (A.R. 208) He indicated that although
17 Coreson was suffering from a number of symptoms, profound fatigue
18 was his most disabling symptom. He further stated that fatigue can
19 be exacerbated by muscle and joint aches, "such that it's often
20 very difficult for people to sort of distinguish within themselves
21 which is which." (A.R. 209)

22 With regard to Coreson's depression, Dr. Beers had prescribed
23 Paxil and Effexor. The doctor indicated depression and other
24 mental disorders also can contribute to extreme fatigue. (A.R.
25 210-11) The doctor indicated Coreson's fatigue could be related to
26 several factors, including his HIV, rheumatoid arthritis, joint
27 pain, loss of his ability to work at his job, and loss of the
28 ability to socialize with his friends. (A.R. 236; see A.R. 230-36)

1 Coreson also had a number of stressors in his personal life which
2 the doctor indicated could trigger depression. (A.R. 240-42)

3 Dr. Beers explained, at some length, how a person with HIV who
4 otherwise appears to have "good" test results (high CD4 counts and
5 low viral load) still can suffer from a variety of HIV-related
6 problems, such as inflammation of the central nervous system, mito-
7 chondrial diseases that can ultimately cause death from metabolic
8 failure, and endocrinologic issues. (A.R. 212-14) He stated
9 doctors have "known for some time that there are patients with HIV
10 whose fatigue is out of proportion with other findings of severity
11 of illness." (A.R. 214) In his practice, he has noticed a simi-
12 larity between rheumatoid arthritis patients and HIV patients in
13 terms of fatigue, where "characteristically a good day is followed
14 by a bad day." (A.R. 214-15) He explained:

15 If somebody feels very well, is more active
16 one day, the next day the bathroom looks like
it's a mile away.

17 And very early on I noticed that with my
18 HIV patients if they had a good day and did
more that characteristically they would be
really incapable of functioning the next day.

19 And my patients finally learned, many of
20 them, would make sure that they would rest for
a day or two before coming to a physician's
appointment.

21 (A.R. 215) Although these types of symptoms are seen more often in
22 people with a higher viral load and lower CD4 counts, doctors also
23 have seen these symptoms "in really severe form in patients with
24 low viral load and high CD4 counts." (*Id.*)

25 Dr. Beers saw Coreson in November 1998, when Coreson presented
26 with profound fatigue, widespread achiness, and depression. The
27 doctor suspected rheumatoid arthritis, which was confirmed with
28 blood tests. Dr. Beers stated he has seen hundreds of patients

1 with rheumatoid arthritis, having taken over the practice of a
2 rheumatologist who was retiring. (A.R. 221-22) The doctor
3 explained that rheumatoid arthritis typically follows a three-step
4 progression, and it is in "the early rheumatoid phase" that people
5 "very characteristically . . . are most fatigued and most system-
6 ically affected[.]" (A.R. 224) He explained that in the early
7 stages of the disease, people may look the most well, but actually
8 suffer the most severe symptoms. This is true even if X-rays fail
9 to show destructive changes in the joints. Dr. Beers stated it
10 generally "will take 10 years of rheumatoid arthritis to develop
11 significant radiologic changes." (A.R. 224-25)

12 The doctor indicated Coreson's condition was worse in 2000
13 than it had been in 1998. In the doctor's opinion, since 1998, it
14 had become increasingly difficult for Coreson to perform his job
15 duties. (A.R. 244-45)

16 A treatment note from Dr. Beers dated October 28, 1999,
17 indicates Coreson "continues to be profoundly disabled secondary to
18 his HIV disease, depression, and rheumatoid arthritis. These all
19 continue to plague him in a synergistic way." (A.R. 457) Coreson
20 had had to "stop[] his medications in August secondary to losing
21 his insurance and not having enough money to afford them." (*Id.*)

22 Coreson saw Dr. Beers on April 7, 2000. Although he continued
23 "to feel profoundly fatigued," he was "functioning at a somewhat
24 better level with his anxiety decrease[d]" since his lawsuit was
25 settled. (A.R. 453) His rheumatoid arthritis was under "somewhat
26 better control," with "no flaring joints at this time." (*Id.*) He
27 was tolerating his HIV medications well. (*Id.*)

1 Coreson underwent an MRI of his cervical spine on July 27,
2 2003. The study showed "[d]egenerative changes at C5-6 and C4-5
3 levels with left paracentral disk abnormalities causing neural
4 foraminal stenosis." (A.R. 439)

5 Coreson saw Dr. Beers on August 12, 2004. Notes indicate
6 Coreson was off his antiretroviral medications at this time, but he
7 was doing well so he was not placed back on therapy. He had
8 experienced a recent flare of his rheumatoid arthritis, with "a
9 marked increase in his stiffness with increase in fatigue . . .
10 somewhat worse in the morning on many occasions but he also has
11 very bad afternoons." (A.R. 291) If he was very active, he would
12 experience a marked exacerbation of symptoms the next day. In
13 addition, he was having "increasing problems with nausea and
14 diarrhea," which the doctor suggested could be due to "possible
15 association between rheumatoid arthritis and some inflammatory
16 bowel disease." (*Id.*)

17 Dr. Beers's treatment notes dated December 16, 2004, indicate
18 Coreson had "been off his anti-retroviral medications for about 3
19 years with a stable CD4 count and a stable viral load," with "no
20 evidence of any opportunistic infections and no progression of
21 disease." (A.R. 290) The plan was for Coreson to stay off
22 medications as long as his CD4 count remained above 250. (*Id.*)
23 The doctor also examined Coreson in connection with his complaint
24 of left shoulder and arm pain that began when he reached behind
25 himself to open a blind. Coreson was "able to passively flex and
26 extend the shoulder about 45 degrees but passive or active
27 abduction of the shoulder [was] completely impossible." (*Id.*) In
28 addition, due to pain, he was unable to rotate the shoulder in any

1 direction. The doctor diagnosed a possible tendon tear, and
2 ordered an MRI for further evaluation before undertaking any
3 treatment. (*Id.*) The MRI was performed on December 23, 2004, and
4 showed "[n]o rotator cuff tear or specific findings of impinge-
5 ment[.]" (A.R. 299)

6 The next treatment note is some sixteen months later, when
7 Coreson saw Dr. Beers on February 13, 2006. His CD4 count had
8 begun to drop, and his viral load had risen suddenly. Coreson was
9 "feeling somewhat more fatigued[.]" (A.R. 288) His rheumatoid
10 arthritis was under fairly good control, and he had "been able to
11 function at a fairly stable level recently with no recent
12 exacerbations of frank synovitis." (*Id.*) The doctor prescribed a
13 combination of antiretroviral medications for Coreson's HIV
14 disease. (*Id.*)

15 On April 11, 2006, Coreson was seen by Laura M. Vanderwerff,
16 M.D. for a complaint of a popping sensation "in his left medial
17 section of his eye," accompanied by a burning-type irritation and
18 redness. (A.R. 285) The doctor noticed Coreson's eyes were
19 slightly jaundiced, which she attributed to one of Coreson's
20 medications. She observed "a pretty distinct conjunctival hemor-
21 rhage on the medial aspect of the left eye," but no foreign body,
22 and no impairment of his vision. (*Id.*) The doctor reassured
23 Coreson that no further treatment was needed at this time, but she
24 encouraged him to follow up with his eye doctor. (*Id.*)

25 When Dr. Beers saw Coreson on April 18, 2006, Coreson com-
26 plained of some resurfacing of the symptoms of his rheumatoid
27 arthritis. On examination, Coreson exhibited markedly decreased
28 grip strength, and "decreased range of motion in the joints of his

1 hands, wrists, and elbows." (A.R. 283) Nevertheless, treatment
2 notes do not indicate any change was made to his rheumatoid
3 arthritis medications. The doctor did, however, make a change to
4 Coreson's HIV medications, in an attempt to deal with ongoing
5 gastrointestinal symptoms from his current medications. (*Id.*)

6 Coreson saw Dr. Beers on October 23, 2006. He was suffering
7 ongoing nausea from his current regimen of HIV medications. The
8 doctor changed the dosing schedule in hopes they could identify
9 which medication was causing the problem. Coreson's rheumatoid
10 arthritis was causing some ongoing stiffness that impaired some of
11 his overall functioning, but otherwise, his condition had not
12 progressed significantly. He indicated he was "happy to continue
13 to manage this with only some occasional p.r.n. opiate therapy and
14 his ongoing hydroxychloroquine." (A.R. 282)

15 By the next time Coreson saw Dr. Beers, on July 18, 2007, he
16 was tolerating his HIV medications well. He had "consistent good
17 suppression of his virus with no apparent adverse affects [sic].
18 His most recent viral load in May was undetectable with a CD4 count
19 up to 570." (A.R. 281) On the other hand, Coreson had been
20 experiencing a flare of his rheumatoid arthritis symptoms for
21 several months, "with associated increase in fatigue." (A.R. 281)
22 He reported "pain and stiffness in his hands, particularly in the
23 morning, with some pain and stiffness in his knees and ankles."
24 (*Id.*) Two of his joints showed slight swelling, without associated
25 erythema or heat. His grip strength was decreased at 16 kg on the
26 right, and 22 kg on the left, "down from his baseline 26 kg and 26
27 kg." (*Id.*) He was taking hydroxychloroquine for his arthritis,
28 and the doctor added salsalate to his medication regimen. (*Id.*)

1 The next treatment note from Dr. Beers is dated nine months
2 later, on April 1, 2008, when Dr. Beers noted Coreson was "doing
3 very well" on his current combination of medications. At this
4 time, Coreson's rheumatoid arthritis was "certainly his most vexing
5 issue[.]" (A.R. 279) He had been experiencing a flare of his
6 arthritis for about four months, "with marked increase in his pain,
7 stiffness, and swelling." (*Id.*) His grip was "profoundly impaired
8 with a 3 kg grip on the right and a 6 kg grip on the left," and
9 Coreson reported that "multiple activities of daily living [were]
10 markedly impaired[.]" (*Id.*) He was having "increased pain without
11 frank warmth or redness in the knees, bilaterally, right greater
12 than left," which was "significantly impairing his ability to
13 walk." (*Id.*) The doctor started Coreson on methotrexate, and
14 planned to add sulfasalazine in one month. (*Id.*)

15 Coreson saw Dr. Beers on May 5, 2008. He was doing well on
16 his current HIV regimen. His grip strength was improving on his
17 rheumatoid arthritis regimen, with grip on the right up to 9 kg.,
18 and on the left up to 20 kg., which the doctor noted was "a sub-
19 stantial improvement." (A.R. 278) Because Coreson was doing well,
20 Dr. Beers decided not to add sulfasalazine yet. (*Id.*)

21 Coreson saw Dr. Beers on June 10, 2008. His HIV remained in
22 good control on his current combination of medications. His
23 current rheumatoid arthritis medications had resulted in "consid-
24 erable improvement in his grip," with his right hand up to 16 kg.,
25 and his left hand up to 22 kg. He also was "having markedly less
26 synovitis, less pain, less erythema and no real warmth." (A.R.
27 277) The doctor added sulfasalazine to get Coreson "on a full 3-
28 drug regimen without TNF alpha inhibitors." (*Id.*) Coreson was

1 pleased with the "overall improvement in his functional status."
2 (*Id.*)

3 On July 22, 2008, Coreson saw Dr. Beers for followup. He was
4 doing well on his current antiretroviral regimen. He was experi-
5 encing "a slight improvement in his overall functional status,
6 though he still [had] trouble gripping things on the right[.]"
7 (A.R. 276) His arthritis medications were continued without
8 change. (*Id.*)

9 Coreson saw Dr. Beers on September 3, 2008, complaining of "a
10 little bit of synovitis in his right hand," and "some slight
11 increase in grip pain" in his left hand. (A.R. 275) His arthritis
12 medications were continued without change. Coreson was doing well
13 on his HIV medication regimen, tolerating the medications well and
14 feeling well on the combination of atazanavir, abacavis, and
15 lamivudine. (*Id.*)

16 Coreson saw Dr. Beers on October 23, 2008. He was experi-
17 encing "considerable stiff joints," and more pain, particularly in
18 his right middle finger. His grip on the right was 15 kg., with
19 left grip of 33 kg. According to Dr. Beers, Coreson's grip
20 strength and pain on the right were becoming much more of a prob-
21 lem, "and impairing his functional status[.]" (A.R. 273) Coreson
22 was referred to Dr. Dan Sager for consultation regarding the
23 possible initiation of Remicade or other therapy. Coreson's HIV
24 was under good control on his current medications, and other than
25 his arthritis symptoms, Coreson's "sense of well being [was]
26 actually quite good[.]" (*Id.*)

27 Dr. Beers saw Coreson on April 22, 2009, for followup. He was
28 tolerating his current medications, with "no evidence of any

1 opportunistic infection[.]” (A.R. 271) Coreson was taking hy-
2 droxychloroquine for his rheumatoid arthritis, and was tolerating
3 it well. He had stopped taking methotrexate in January, due to
4 nausea. His grip strength was significantly improved on the right,
5 at 25 kg, but was decreased somewhat on the left, at 27 kg.
6 Coreson was getting more exercise and was improving his functional
7 status, which he attributed, at least somewhat, to regular therapy
8 for his vitamin D deficiency. (*Id.*)

9 Coreson saw Dr. Beers on September 2, 2009. He was tolerating
10 his medications well, “with no evidence of any major toxicity [and]
11 a very stable immunologic response[.]” (A.R. 269) Coreson had had
12 a brief flare of his rheumatoid arthritis in July, but he
13 “[d]ecreased his activity briefly and was able to ride it through.”
14 (*Id.*) The doctor indicated Coreson had to “be very careful to
15 avoid too much activity,” but he was “able to carry on regular
16 activities of daily living at a somewhat attenuated level.” (*Id.*)
17 He exhibited “slightly decreased range of motion,” with his worst
18 joints being those in his feet and hands. He was started on a
19 statin to lower his cholesterol. (*Id.*)

20 Coreson saw Dr. Beers for followup on December 22, 2009. His
21 HIV was well controlled on his current medications, and he was not
22 experiencing adverse side effects from the medications. His
23 rheumatoid arthritis also was under good control currently, with
24 “relatively little in the way of symptoms in hands or feet in
25 particular.” (A.R. 267) Coreson had had two episodes of cardiac
26 dysrhythmia in the last few months, with symptoms of lightheaded-
27 ness, irregular heartbeat, and on one occasion, paroxysmal atrial
28

1 fibrillation. Dr. Beers noted his concern about these episodes,
2 and planned to order further testing. (*Id.*)

3 Coreson saw Dr. Beers on October 8, 2010, for followup. With
4 regard to his HIV, Coreson was doing well on his medications, and
5 the doctor's notes indicate his "viral load [had] been persistently
6 undetectable." (A.R. 265) His CD4 count had risen, and his
7 cholesterol was under good control. The doctor indicated Coreson's
8 current medications "should be a good and stable regimen for him."
9 (*Id.*) Coreson's rheumatoid arthritis, however, was worsening. He
10 was experiencing more pain in his hands, with "frank synovitis in
11 2 joints in the right hand and in 1 joint [in] the left hand."
12 (*Id.*) His grip strength was markedly reduced on the right, down
13 from 25 kg. at his last visit to 9 kg. currently. The doctor put
14 Coreson back on methotrexate, and also counseled Coreson "about
15 alternative therapies including injectables." (*Id.*) Coreson was
16 still having some episodes of PSVT, usually during walks. The
17 doctor switched him from atenolol to metoprolol. (*Id.*)

18
19 **B. Coreson's Testimony**

20 Coreson stated he has not worked since his alleged disability
21 onset date, having left his job when he "could no longer carry on
22 [his] duties." (A.R. 30) He is HIV-positive, and has rheumatoid
23 arthritis. As part of the HIV disease, he also suffers from
24 neuropathy in both of his hands and feet. (A.R. 31) He stated
25 that when he was first diagnosed HIV-positive, in September 1992,
26 he was told he had only five years to live. (*Id.*; A.R. 44)

27 Coreson was able to continue working from his HIV diagnosis in
28 1992, until he stopped working in November 1998. He stated his

1 "medications were so severe back then that . . . [his] function
2 decreased." (A.R. 44) He indicated his job at Oregon Fish and
3 Wildlife "was a nightmare." (*Id.*) He described his duties as
4 follows: "I was in charge of the administrative functions, which
5 included the entire accounting division, information systems divi-
6 sions, licensings [phonetic] divisions, real estate divisions.
7 Planning the legislature and presenting the budget." (*Id.*) As his
8 health declined, his stress level increased, and his doctor told
9 him repeatedly that stress was "not good for [him]." (*Id.*) In
10 addition, he suffered from frequent fatigue from his medications,
11 as well as nausea and confusion. He had difficulty concentrating,
12 and he began relying more and more on his staff to do tasks that
13 he, himself, should have been doing. (A.R. 45) Although he tried
14 to keep up his pace, he was unable to do so. (*Id.*)

15 During the same period of time, he also was diagnosed with
16 rheumatoid arthritis. Before his diagnosis, he had begun suffering
17 "a lot of joint pain and swelling." (A.R. 45) His fatigue became
18 so extreme, he was unable to work a full day. He stated, "I was
19 coming home three times a day to just flop on the bed and relax."
20 (*Id.*) Although his employer accommodated these breaks, Coreson
21 eventually felt that even with the breaks, he could no longer
22 manage his job. He testified:

23 I was feeling horribly guilty, first of all,
24 about not being able to do my job, and two,
25 relying on particularly my assistant and
26 putting a lot of burden on her. And finally,
27 in November of 1998 my physician said, "You
28 know, you really have to quit working. You're
going to kill yourself. The stress is not
doing anything." And my hands were swollen
like water balloons at that time [leaving him
unable to keyboard].

1 (A.R. 46)

2 Coreson stated his condition continued to deteriorate through
3 the end of 2004. The side effects from his medications were "just
4 horribly obnoxious," including dizziness, nausea, and general
5 fatigue. (A.R. 46-47)

6
7 ***C. Medical Expert's Testimony***

8 William Spence, M.D. testified as a medical expert. He stated
9 he is "Board-certified in internal medicine, pulmonary disease, and
10 critical care." (A.R. 25) He has never examined or treated
11 Coreson, but has reviewed Coreson's medical records. Dr. Spence
12 found Coreson has "two salient conditions." (A.R. 32) He first
13 addressed Coreson's HIV disease.

14 According to Dr. Spence, Coreson was first diagnosed HIV-
15 positive in about 1992. He initially showed "grossly abnormal
16 levels of the two indices of activity"; i.e., "his viral loads
17 . . . [and] his CD4 counts." (A.R. 32-33) Coreson initially had
18 a high viral load and low CD4 count, but he responded well to
19 retroviral therapy, such that by 2010, there was no detectable
20 viral load, and his CD4 count had come up to a satisfactory level.
21 (A.R. 32-33) In 1999, Coreson had "an episode of herpes zoster
22 infection," that was controlled by medication, and "[a]pparently
23 did not produce any kind of significant impairments - or persistent
24 impairments, anyway." (A.R. 33) Other than this infection,
25 Dr. Spence could find no evidence in the record that Coreson
26 suffered other infections characteristically seen in individuals
27 with HIV disease. (*Id.*)

1 Coreson's other condition evidenced in the record is
2 rheumatoid arthritis. Dr. Spence indicated this had been "sort of
3 a slow, progressive thing, . . . not . . . marked by any described
4 deformities," but "associated with periods of considerable amount
5 of pain." (A.R. 34) Objective findings showed diminished strength
6 in Coreson's hands; however, Dr. Spence found "this seemed to
7 improve under therapy," and x-rays showed only minimal degenerative
8 changes in his hands, right more than left. (A.R. 34-35) The
9 April 2003 x-rays of Coreson's hands showed "no evidence of erosion
10 of bones." (A.R. 35)

11 Coreson had "chronic problems with recurrent chest pain."
12 (A.R. 35) However, Dr. Spence found no evidence of "any clear-cut
13 cardiac problem." (*Id.*) Although the record contains notes indi-
14 cating a past echocardiogram had shown a mitral valve prolapse,
15 Dr. Spence could not find evidence in the record of "imaging
16 studies of physical findings that suggested the presence of pro-
17 lapse." (*Id.*) The only actual cardiac event evidenced in the
18 record occurred in about December of 2009, when Coreson "began
19 experiencing palpitations in the chest." (*Id.*) Doctors "noted a
20 rapid rhythm," and an EKG "showed atrial fibrillation"; however,
21 this was "paroxysmal" and "did not persist." (*Id.*) The event led
22 to testing with a Holter monitor, which "demonstrated what we refer
23 to as paroxysmal supraventricular tachycardia. In other words,
24 just irregular but rapid heartbeat occurring in spasms." (A.R. 35-
25 36) However, according to Dr. Spence, this was the only time
26 atrial fibrillation was noted, and "the diagnosis was not supported
27 by further studies." (A.R. 36) He noted Coreson "continues to
28 have episodes of rapid palpitation from time-to-time . . . but so

1 far, up to the present, no cardiac pathology, symptomatology except
2 the report that he has a chest pain." (*Id.*)

3 Dr. Spence also noted Coreson has "sort of a chronic low-level
4 pain in his neck," that resulted in an MRI in July 2003. (*Id.*)
5 The MRI showed some degenerative changes at C4-5, and C5-6, with
6 "some bulging discs present . . . and also some foraminal stenosis
7 of a degenerative type that was seen - but no clear-cut compromise
8 of the nerves that could be noted." (A.R. 37) Coreson also has
9 "some limitation of his ability to rotate his head," and "problems
10 with headaches, but no other problems[.]" (*Id.*)

11 Dr. Spence concluded that Coreson's documented problems are
12 HIV disease, currently "controlled," and "rheumatoid arthritis
13 [that] has not shown any further progressive, destructive, or per-
14 sisting symptoms." (*Id.*) He found Coreson's impairments did not
15 meet or equal a listing, either at the time of the hearing, or in
16 2004, prior to Coreson's date last insured. (A.R. 37-38)
17 Dr. Spence indicated he had reviewed Dr. Beers's deposition testi-
18 mony, which he characterized as focusing largely on Coreson's
19 excessive fatigue at that time, but Dr. Spence did not see anything
20 from 2000 forward indicating Coreson continued to suffer from that
21 degree of fatigue. (A.R. 38-39)

22 Dr. Spence acknowledged that Coreson had suffered from
23 depression, but he "felt that it was almost [a] natural expectation
24 considering not only the diagnosis but at the time - in the
25 beginning of his HIV, before he started treatment, he was suffering
26 from symptoms and the knowledge of the kind of condition he
27 had. . . . [W]hen he was told of the diagnosis, which was in the
28 '90s, he was told that probably he would not survive more than five

1 years." (A.R. 39-40) According to Dr. Spence, those facts,
2 together with Coreson's worsening rheumatoid arthritis during the
3 same time period, logically would lead to some depression. (A.R.
4 40-41) Dr. Spence and the ALJ agreed that Dr. Spence was not
5 qualified to comment on depression as a psychiatric diagnosis, and
6 Dr. Spence noted there was no psychiatric evaluation in the record.
7 (A.R. 43)

8
9 ***D. Third-Party Testimony***

10 Coreson's daughter Latricia Payer testified that she is an
11 attorney, but her law license has been inactive since 2004. At the
12 time of the ALJ hearing, she was working as a publicist, managing
13 all of the public relations for the Microsoft legal department.
14 (A.R. 48-49)

15 In 1998, Payer was living with her father in Portland. Except
16 for the two years from 2005 to 2007, she has lived in Portland
17 continuously. She stated the family knew, in the early 1990s, that
18 Coreson was HIV-positive. During the '90s, she observed her
19 father's health become progressively worse. He frequently was
20 fatigued. He used to play the piano, but because of the pain in
21 his hands, he became unable to play. He also "always crocheted and
22 he couldn't hold the crochet needle." (A.R. 50) "[H]e sometimes
23 found it therapeutic to bake bread, but . . . that was an exercise
24 that was also painful for him." (*Id.*) Payer stated there were a
25 lot of physical activities her father found challenging. (*Id.*)

26 In Payer's opinion, Coreson's depression "was an outgrowth of
27 his physical deterioration." (*Id.*) His inability to continue
28 working "caused pretty significant financial stress. His relation-

ships were not super successful. It was not a happy time. And there didn't appear to be a lot of hope on the horizon[.]" (A.R. 50-51)

Payer did not personally observe that her father had difficulty concentrating, or sticking to a task. She "knew he was fatigued a lot," and he had difficulty doing anything, even sitting in a chair and reading, for any period of time. She stated, "Everything was difficult." (A.R. 51)

E. Vocational Expert's Testimony

The VE stated Coreson has "a singular work history as a director of a government agency," which is considered a sedentary, skilled job with an SVP of 8.⁴ (A.R. 52) The ALJ asked the VE if Coreson's job would have had transferable skills to work requiring "a little lower SVP, perhaps to [a] semi-skilled position of some sort." (*Id.*) The VE indicated there would not be any transferable skills to semi-skilled work with an SVP of 3 or 4. (A.R. 54-55)

The VE stated if an individual, who was 55 or 56 years old in 2004, was able to perform the full range of sedentary work, then "he would be able to do the past work of the director of the

⁴Jobs are classified with an "SVP," or level of "specific vocational preparation" required to perform the job, according to the *Dictionary of Occupational Titles*. The SVP "is defined as the amount of lapsed time required by a typical worker to learn the techniques, acquire the information, and develop the facility needed for average performance in a specific job-worker situation." *Davis v. Astrue*, slip op., 2011 WL 6152870, at *9 n.7 (D. Or. Dec. 7, 2011) (Simon, J.) (citation omitted). "The DOT identifies jobs with an SVP level of 1 or 2 as unskilled, jobs with an SVP of 3 or 4 as semi-skilled, and jobs with an SVP of 5 or higher as skilled." *Whitney v. Astrue*, slip op., 2012 WL 712985, at 3 (D. Or Mar. 1, 2012) (Brown, J.) (citing SSR 00-4p).

1 government agency." (A.R. 54) However, if that individual were
 2 "unable to complete a normal work day such that he could only work
 3 about six hours a day," then he would be unable to maintain full-
 4 time employment. (A.R. 55)

6 **III. DISABILITY DETERMINATION AND THE BURDEN OF PROOF**

7 **A. Legal Standards**

8 A claimant is disabled if he or she is unable to "engage in
 9 any substantial gainful activity by reason of any medically deter-
 10 minable physical or mental impairment which . . . has lasted or can
 11 be expected to last for a continuous period of not less than 12
 12 months[.]" 42 U.S.C. § 423(d)(1)(A).

13 "Social Security Regulations set out a five-step sequential
 14 process for determining whether an applicant is disabled within the
 15 meaning of the Social Security Act." *Keyser v. Commissioner*, 648
 16 F.3d 721, 724 (9th Cir. 2011) (citing 20 C.F.R. § 404.1520). The
 17 *Keyser* court described the five steps in the process as follows:

18 (1) Is the claimant presently working in a
 19 substantially gainful activity? (2) Is the
 20 claimant's impairment severe? (3) Does the
 21 impairment meet or equal one of a list of
 22 specific impairments described in the regula-
 23 tions? (4) Is the claimant able to perform
 any work that he or she has done in the past?
 and (5) Are there significant numbers of jobs
 in the national economy that the claimant can
 perform?

24 *Keyser*, 648 F.3d at 724-25 (citing *Tackett v. Apfel*, 180 F.3d 1094,
 25 1098-99 (9th Cir. 1999)); see *Bustamante v. Massanari*, 262 F.3d
 26 949, 953-54 (9th Cir. 2001) (citing 20 C.F.R. §§ 404.1520 (b)-(f)
 27 and 416.920 (b)-(f)). The claimant bears the burden of proof for
 28 the first four steps in the process. If the claimant fails to meet

1 the burden at any of those four steps, then the claimant is not
2 disabled. *Bustamante*, 262 F.3d at 953-54; see *Bowen v. Yuckert*,
3 482 U.S. 137, 140-41, 107 S. Ct. 2287, 2291, 96 L. Ed. 2d 119
4 (1987); 20 C.F.R. §§ 404.1520(g) and 416.920(g) (setting forth
5 general standards for evaluating disability), 404.1566 and 416.966
6 (describing "work which exists in the national economy"), and
7 416.960(c) (discussing how a claimant's vocational background
8 figures into the disability determination).

9 The Commissioner bears the burden of proof at step five of the
10 process, where the Commissioner must show the claimant can perform
11 other work that exists in significant numbers in the national
12 economy, "taking into consideration the claimant's residual
13 functional capacity, age, education, and work experience." *Tackett*
14 *v. Apfel*, 180 F.3d 1094, 1100 (9th Cir. 1999). If the Commissioner
15 fails meet this burden, then the claimant is disabled, but if the
16 Commissioner proves the claimant is able to perform other work
17 which exists in the national economy, then the claimant is not
18 disabled. *Bustamante*, 262 F.3d at 954 (citing 20 C.F.R.
19 §§ 404.1520(f), 416.920(f); *Tackett*, 180 F.3d at 1098-99).

20 The ALJ also determines the credibility of the claimant's
21 testimony regarding his or her symptoms:

22 In deciding whether to admit a claimant's
23 subjective symptom testimony, the ALJ must
24 engage in a two-step analysis. *Smolen v.*
25 *Chater*, 80 F.3d 1273, 1281 (9th Cir. 1996).
26 Under the first step prescribed by *Smolen*,
27 . . . the claimant must produce objective
28 medical evidence of underlying "impairment,"
and must show that the impairment, or a combi-
nation of impairments, "could reasonably be
expected to produce pain or other symptoms."
Id. at 1281-82. If this . . . test is satis-
fied, and if the ALJ's credibility analysis of
the claimant's testimony shows no malingering,

1 then the ALJ may reject the claimant's testi-
2 mony about severity of symptoms [only] with
3 "specific findings stating clear and con-
4 vincing reasons for doing so." *Id.* at 1284.

5
6 *Batson v. Commissioner*, 359 F.3d 1190, 1196 (9th Cir. 2004).

7 ***B. The ALJ's Decision***

8 The ALJ found Coreson's date last insured was December 31,
9 2004. He found Coreson has not engaged in substantial gainful
10 activity from his alleged disability onset date of November 17,
11 1998, through December 31, 2004. He found that, through his date
12 last insured, Coreson had severe impairments consisting of "HIV,
13 rheumatoid arthritis, and degenerative disc disease of the cervical
14 spine." (A.R. 13)

15 The ALJ found Coreson's depression caused no more than minimal
16 limitation in his ability to perform basic mental work activities,
17 and therefore his depression was not a severe impairment. (*Id.*)
18 He found Coreson had only mild limitations in his activities of
19 daily living, social functioning, and concentration, persistence,
20 or pace, and Coreson had no episodes of decompensation. (*Id.*) He
21 also found Coreson's left shoulder injury and hypertension were not
22 severe impairments, and any cardiac problems were not severe
23 impairments "during the time period at issue." (A.R. 14, 15)

24 Although the ALJ found Coreson to have severe impairments, he
25 found those impairments, singly or in combination, did not meet or
26 medically equal any listed impairment in the Regulations. (A.R.
27 15)

28 The ALJ found that, through his date last insured, Coreson
retained the residual functional capacity "to perform the full

1 range of sedentary work as defined in 20 CFR 404.1567(a), which
2 includes lifting and carrying up to 10 pounds occasionally and less
3 than 10 pounds frequently, standing and/or walking up to two hours
4 in an eight-hour workday, and sitting up to six hours in an eight-
5 hour workday." (A.R. 16) In reaching this conclusion, the ALJ
6 found Coreson's allegations regarding his symptoms were not fully
7 credible. He cited the following reasons for this conclusion:

8 The available medical evidence of record does
9 not support a conclusion of disability. For
10 example, the records from Legacy Clinic in
11 2004 show no flares of rheumatoid arthritis in
12 a year and only a small flare at that point,
13 with no swelling or deformity. Additionally,
14 anti-retroviral therapy was effective in
15 controlling [Coreson's] HIV symptoms. A rec-
16 ord from December 2004 notes that [Coreson]
17 had been off anti-retroviral medications for
18 three years, with a stable CD4 count and
19 stable viral load. There was also no evidence
20 of opportunistic infections and no progression
21 of disease. Furthermore, an examination on
22 August 12, 2004 noted normal orthopedic and
23 neurological exams. Additionally, although
24 [Coreson] testified at the hearing that
25 medical side effects were severely limiting,
26 treatment records from April 2000 note he was
27 tolerating medications without difficulty and
28 his rheumatoid arthritis was under better
control. Accordingly, the treatment records
during the time period at issue, from the
alleged onset date to the date last insured,
do not document objective findings that would
support greater limitations than those
outlined above.

(A.R. 16-17; citations to exhibits omitted)

 The ALJ gave Dr. Spence's opinion "great weight in determining
the severity of [Coreson's] symptoms prior to the date last
insured, as well as formulating the residual functional
capacity[.]" (A.R. 17) The ALJ noted the state agency physicians'
opinions "also supported a finding of 'not disabled,'" although
those physicians had "concluded that there was insufficient evi-

1 dence in the record to assess[] a mental or physical residual func-
2 tional capacity for the time period prior to the date last
3 insured." (*Id.*)

4 The ALJ rejected Dr. Beers's opinion that Coreson would be
5 unable to work "for several hours at a time, with difficulty
6 attending to detail, maintaining attention, and fatigue," and
7 Coreson also could not sustain full-time work due to his rheumatoid
8 arthritis. (*Id.*) The ALJ gave the following reasons for rejecting
9 Dr. Beers's opinions:

10 Dr. Beers did not provide a function-by-func-
11 tion analysis of [Coreson's] abilities and/or
12 limitations. Furthermore, his statements are
13 unsupported by the contemporaneous treatment
14 records in evidence, that do not document dis-
15 abling levels of fatigue, or objective find-
16 ings that would support such restrictive
17 limitations. For example, a record from April
18 2000 notes that [Coreson] reported continuing
19 fatigue, but he was actually functioning at a
20 better level. Additionally, anti-retroviral
21 therapy and medication for rheumatoid arthri-
22 tis were effective in controlling his symp-
23 toms. Accordingly, the undersigned has given
24 greater weight to Dr. Spence's opinion, as
25 well as the objective medical evidence, than
26 Dr. Beers'[s] deposition testimony that [Core-
27 son] could not sustain full time work.

28 (A.R. 17-18)

29 The ALJ rejected the testimony of Coreson's daughter because
30 (1) "the period under discussion was eight to fourteen years ago,
31 and memories do fade or become colored over time"; (2) "it would be
32 normal for her to support [Coreson's] allegations"; and (3) "the
33 medical evidence of record does not support [Coreson's] allega-
34 tions, and . . . Payer's testimony is not consistent with thee
35 medical evidence of record[.]" (A.R. 18)

1 The ALJ found that, through his date last insured, Coreson
2 "was capable of performing past relevant work as a director,
3 government agency." (*Id.*) He therefore concluded Coreson was not
4 disabled at any time from his alleged onset date of November 17,
5 1998, through his date last insured of December 31, 2004. (A.R.
6 19)

7 8 **IV. STANDARD OF REVIEW**

9 The court may set aside a denial of benefits only if the
10 Commissioner's findings are "'not supported by substantial evidence
11 or [are] based on legal error.'" *Bray v. Comm'r of Soc. Sec.*
12 *Admin.*, 554 F.3d 1219, 1222 (9th Cir. 2009) (quoting *Robbins v.*
13 *Soc. Sec. Admin.*, 466 F.3d 880, 882 (9th Cir. 2006)); accord *Black*
14 *V. Comm'r of Soc. Sec. Admin.*, slip op., 2011 WL 1930418, at *1
15 (9th Cir. May 20, 2011). Substantial evidence is "'more than a
16 mere scintilla but less than a preponderance; it is such relevant
17 evidence as a reasonable mind might accept as adequate to support
18 a conclusion.'" *Id.* (quoting *Andrews v. Shalala*, 53 F.3d 1035,
19 1039 (9th Cir. 1995)).

20 The court "cannot affirm the Commissioner's decision 'simply
21 by isolating a specific quantum of supporting evidence.'" *Holohan*
22 *v. Massanari*, 246 F.3d 1195, 1201 (9th Cir. 2001) (quoting *Tackett*
23 *v. Apfel*, 180 F.3d 1094, 1097 (9th Cir. 1998)). Instead, the court
24 must consider the entire record, weighing both the evidence that
25 supports the Commissioner's conclusions, and the evidence that
26 detracts from those conclusions. *Id.* However, if the evidence as
27 a whole can support more than one rational interpretation, the
28 ALJ's decision must be upheld; the court may not substitute its

1 judgment for the ALJ's. *Bray*, 554 F.3d at 1222 (citing *Massachi v.*
2 *Astrue*, 486 F.3d 1149, 1152 (9th Cir. 2007)).

3 4 **V. DISCUSSION**

5 Coreson argues the ALJ erred in three respects: (1) rejecting
6 Dr. Beers's opinions without giving "clear and convincing" or
7 "specific and legitimate" reasons for doing so; (2) rejecting
8 Coreson's testimony "without providing any reasons at all for doing
9 so"; and (3) rejecting the testimony of Coreson's daughter "without
10 offering reasons 'germane' to the witness." Dkt. #12, p. 2.
11 Coreson argues the record evidence establishes disability, and the
12 case should be remanded for immediate calculation and payment of
13 benefits. Dkt. #12, *passim*.

14 The Commissioner agrees the ALJ's decision was not supported
15 by substantial evidence, and "was not free of legal error." Dkt.
16 #17, p. 2. The Commissioner states "[t]he ALJ's evaluation of
17 medical evidence was not free of legal error," and "[t]he ALJ's
18 step four finding is not supported with substantial evidence or
19 free of legal error." *Id.*, pp. 8-10. However, the Commissioner
20 argues that rather than remanding for payment of benefits, the
21 court should remand the case for further proceedings, to allow
22 Coreson "a de novo opportunity to present his case." *Id.*, p. 11.

23 The Commissioner argues that although the record evidence does
24 not prove Coreson is disabled, "and there are varying medical
25 opinions on his functional ability" (i.e., the opinions of Drs.
26 Beers and Spence), "the record does support symptoms opined by
27 Dr. Beers that should have been included in the RFC." *Id.*, p. 9.
28 She argues that because it is not clear whether including those

1 limitations in Coreson's RFC would render him unable to "perform
2 other *unskilled work* existing in the national economy," the case
3 should be remanded with directions to the ALJ to credit Dr. Beers's
4 testimony, reformulate the RFC on that basis, and then obtain
5 further vocational evidence regarding Coreson's ability to work
6 given the revised RFC. *Id.*, pp. 8-11 (emphasis added).

7 As Coreson notes in his reply brief, the Commissioner did not
8 defend the ALJ's decision on any grounds. She did not address the
9 arguments that the ALJ improperly rejected Coreson's own testimony,
10 or the testimony of his daughter. Dkt. #18, p. 2. The Commis-
11 sioner concedes "the judgment must go to [Coreson]." Dkt. #17,
12 p. 2. Thus, the only question for the court to decide is whether
13 the case should be remanded for further proceedings, or for
14 immediate payment of benefits.

15 The Ninth Circuit Court of Appeals has held that when an ALJ
16 improperly rejects controlling evidence, the record is fully
17 developed, and "it is clear from the record that the ALJ would be
18 required to find the claimant disabled were [the improperly-
19 rejected] evidence credited," the court should credit the rejected
20 evidence and remand the case for an immediate award of benefits.
21 *Benecke v. Barnhart*, 379 F.3d 587, 593 (9th Cir. 2004) (citations
22 omitted). The controlling question here is whether any further
23 development of the record is necessary, or whether the current
24 record supports a finding of disability.

25 The Commissioner appears to concede that including Coreson's
26 limitations described by Dr. Beers in the RFC would prevent Coreson
27 from performing skilled or semi-skilled work. Indeed, the
28 Commissioner requests remand to determine whether, once the RFC has

1 been revised, Coreson would be able to "perform other *unskilled*
2 work existing in the national economy." Dkt. #17, p. 9 (emphasis
3 added). Further, the VE testified Coreson does not have skills
4 that would transfer to semi-skilled work. (A.R. 55)

5 The Commissioner's Medical-Vocational Guidelines provide that
6 individuals approaching advanced age (i.e., age 50-54) who are, as
7 a result of their impairments, limited to sedentary work, "can no
8 longer perform vocationally relevant past work and have no
9 transferable skills," ordinarily are entitled to a finding of
10 disability.⁵ 20 C.F.R. pt. 404, subpt. P, app. 2, §§ 200.01(g),
11 201.14; see, e.g., *Scott v. Comm'r*, slip op., 2013 WL 3368969, at
12 *2 (D. Or. July 2, 2013) (Coffin, MJ) (citing the regulation for
13 the proposition that "a person closely approaching advanced age
14 (50-54), who is a highschool graduate with no transferable skills
15 is disabled if limited to sedentary work"). Coreson meets these
16 requirements.

17 The court finds no further development of the record is neces-
18 sary to find Coreson disabled prior to his date last insured.
19 Substantial evidence supports such a finding.

20 21 **VI. CONCLUSION**

22 For the reasons discussed above, the undersigned recommends
23 the Commissioner's decision be reversed, and the case be remanded
24 for immediate calculation and payment of benefits.

25
26
27 ⁵The exception, applicable to "recently completed education
28 which provides for direct entry into sedentary work," does not
apply here.

1 **VII. SCHEDULING ORDER**

2 These Findings and Recommendations will be referred to a
3 district judge. Objections, if any, are due by **December 22, 2014**.
4 If no objections are filed, then the Findings and Recommendations
5 will go under advisement on that date. If objections are filed,
6 then any response is due by **January 8, 2015**. By the earlier of the
7 response due date or the date a response is filed, the Findings and
8 Recommendations will go under advisement.

9 IT IS SO ORDERED.

10 Dated this 3rd day of December, 2014.

11
12 /s/ Dennis J. Hubel

13 _____
14 Dennis James Hubel
 Unites States Magistrate Judge